

**MINUTES  
of the  
FIFTH MEETING  
of the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**October 20, 2014  
Santa Claran Hotel  
Espanola**

**October 21-22, 2014  
State Capitol, Room 307  
Santa Fe**

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, on Monday, October 20, 2014, at 9:17 a.m. on the seventh floor of the Santa Claran Hotel in Espanola.

**Present**

Rep. James Roger Madalena, Chair  
Sen. Gerald Ortiz y Pino, Vice Chair  
Rep. Nora Espinoza  
Rep. Doreen Y. Gallegos (10/20, 10/21)  
Sen. Gay G. Kernan  
Sen. Mark Moores (10/22)  
Sen. Benny Shendo, Jr.

**Absent**

Rep. Terry H. McMillan

**Advisory Members**

Sen. Sue Wilson Beffort (10/21, 10/22)  
Sen. Craig W. Brandt (10/21, 10/22)  
Sen. Jacob R. Candelaria (10/21)  
Rep. Nathan "Nate" Cote  
Sen. Linda M. Lopez  
Sen. Cisco McSorley  
Sen. Bill B. O'Neill (10/21, 10/22)  
Sen. Mary Kay Papen (10/21, 10/22)  
Sen. Nancy Rodriguez  
Sen. Sander Rue (10/22)  
Rep. Edward C. Sandoval  
Rep. Elizabeth "Liz" Thomson

Rep. Phillip M. Archuleta  
Rep. Miguel P. Garcia  
Sen. Daniel A. Ivey-Soto  
Rep. Sandra D. Jeff  
Rep. Paul A. Pacheco  
Rep. Vickie Perea  
Sen. William P. Soules

**Guest Legislator**

Rep. Nick L. Salazar

(Attendance dates are noted for members not present for the entire meeting.)

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Shawn Mathis, Staff Attorney, LCS  
Rebecca Griego, Records Officer, LCS  
Carolyn Peck, LCS  
Nancy Ellis, LCS

**Guests**

The guest list is in the meeting file.

**Handouts**

Handouts and other written material are in the meeting file.

**Monday, October 20 — Santa Claran Hotel****Welcome and Introductions**

Representative Madalena welcomed those assembled and asked committee members and he staff to introduce themselves. He then introduced J. Michael Chavarria, governor of the Pueblo of Santa Clara. Governor Chavarria offered a traditional prayer and followed with introductions of his staff and tribal department heads who were in the audience.

**Health and Human Services in the Pueblo of Santa Clara**

Governor Chavarria said the Pueblo of Santa Clara still faces the imminent threat of flooding stemming from the 2011 Las Conchas fire, and he described ongoing emergency stabilization projects at the pueblo (see handouts). There have been four related presidential disaster declarations, he said, with two awards resting with the state and two in which the Pueblo of Santa Clara is the direct grantee, all with total damage awards of more than \$100 million. Governor Chavarria also described a national disaster resilience competition through the U.S. Department of Housing and Urban Development, in partnership with The Rockefeller Foundation, for which the pueblo is eligible and plans to apply by the March 2015 deadline. Winning proposals will receive \$1 billion for implementation of long-term recovery, restoration of infrastructure and housing and economic revitalization that demonstrate how communities can plan for a more resilient future. The Pueblo of Santa Clara is part of a national disaster recovery framework and collaborates with federal, state and tribal agencies and organizations, including the U.S. Army Corps of Engineers, the federal Bureau of Reclamation, the federal Bureau of Indian Affairs, the U.S. Forest Service, the Valles Caldera National Preserve and private foundations.

The Pueblo of Santa Clara is the site of a regional senior citizens and adult daycare center, with support coming from the state and from the eight northern pueblos. The programs are housed in a 10,800-square-foot facility in Espanola, and Governor Chavarria invited committee members to stop by for a tour of the center. Adults with special needs and seniors are provided with meaningful activities that stimulate both the mind and the body, he said. A long-

range goal of the program is to implement third-party billing and eventually to become self-sufficient.

Governor Chavarria described water and wastewater projects at the pueblo, which has secured grant funding from federal, state and tribal sources to replace aging infrastructure and to help provide adequate fire protection by the end of 2015. Santa Clara Pueblo Behavioral Health offers many services in mental health and substance abuse counseling, treatment and prevention, he continued, and plans are under way to assess efforts and expand services. The pueblo also is a recipient of a systems-of-care grant, now in its final year, from the Children, Youth and Families Department (CYFD). Third-party billing for behavioral health, community health representatives (CHRs), transportation for CHRs and senior center and adult daycare services remains problematic, Governor Chavarria said, and guidance from the CYFD has not been robust. He described services of the Pueblo of Santa Clara for children and adults and the need for adequate funding as the tribal community continues to grow.

Governor Chavarria described plans for a proposed 84,346-square-foot regional health facility in Espanola that will replace the pueblo's current health clinic and will be a joint venture with the Indian Health Service (IHS) and six neighboring tribes and communities. A 20-acre site has been identified for the \$40.5 million project that will include primary care, behavioral health, dental, vision and other specialty care services. The Pueblo of Santa Clara would own the facility, but the IHS would provide staffing, and services could be expanded to include consumers other than tribal members. He informed the committee that the Pueblo of Santa Clara intends to apply for designation of the health clinic as a facility operating as a tribal "638 facility", meaning a facility operating under tribal control pursuant to the federal Indian Self-Determination and Education Assistance Act. As a 638 facility, Governor Chavarria said, third-party billing will become crucial. A feasibility study will be part of the Phase II application for the proposed new facility.

Referring back to the presentation on federal funds for damage from flooding, a committee member asked Governor Chavarria about delays by the state in forwarding those funds to the tribe. It is a problem, the governor stated, because much of the money does not arrive until a year or more later. The Pueblo of Santa Clara just received a presidential waiver to increase the federal match from 75 percent to 90 percent for one of the projects, he added. The chair invited Governor Chavarria and his staff to attend the next two days of the LHHS meeting in Santa Fe.

### **Pueblo of Jemez Experiences with Medicaid Centennial Care**

Maria K. Clark, director of the Pueblo of Jemez Health and Human Services Department, described the accredited ambulatory health care center operated by the Pueblo of Jemez (see handout). In 2012, the pueblo decided to expand upon its federal mission and opened its doors to non-Indian residents in surrounding communities, she said, and now a small IHS program has been transformed into a full-service outpatient health care facility. As part of its Centennial Care (CC) plan, the state's Human Services Department (HSD) proposed a new mandate to require

Native Americans to enroll in Medicaid managed care plans, despite the fact that federal law prohibits such a mandate, Ms. Clark explained. The HSD's request to the Centers for Medicare and Medicaid Services (CMS) for a waiver from this prohibition was widely opposed by tribal leaders, who cited concerns about access to services, timely payments and culturally competent care. In 2013, the CMS rejected the state's plan to make Medicaid managed care mandatory for Native Americans, although individuals who require long-term care are still required to be enrolled with a managed care organization (MCO). Tribal members and many others continue to support passage of a state law to prevent mandatory enrollment of any Native American into a managed care plan and preserving fee-for-service (FFS) Medicaid as the default option, Ms. Clark said. Despite the CMS denial, the HSD auto-enrolled thousands of Native Americans into its MCOs, and efforts to opt out have been very difficult. On average, it has been taking three to four months to process an opt-out request, and currently, nearly 30 percent of patients at the Jemez health care center are waiting to be enrolled in FFS Medicaid, according to Ms. Clark. These are perhaps as many as 7,000 Native Americans waiting to opt out. While MCOs receive, on average, \$3,284 per member per month, there is currently no reimbursement to tribal health centers for care coordination under FFS Medicaid. The state could reap considerable savings by allowing American Indian health facilities to be reimbursed for case management, Ms. Clark asserted. Other reimbursement issues include double payment of claims from previous MCOs (Loveland and Amerigroup), some of which still have not been resolved. Care coordination for tribal long-term-care recipients is nearly nonexistent, according to a recent survey that revealed that none of those interviewed knew who their assigned care coordinator was or what level of care they had been assigned by their MCOs. Ms. Clark said she and her staff remain eager to work with the HSD toward resolution of enrollment and reimbursement issues.

On questioning, Ms. Clark and Lisa Maves, a medical social worker with the Pueblo of Jemez Health and Human Services Department, discussed with committee members the following topics.

*Identification of Native Americans.* Julie Weinberg, director of the Medical Assistance Division of the HSD and administrator of CC, was recognized from the audience, and she denied that there was any attempt by her division to auto-enroll Native Americans. The system relies on self-identification, Ms. Weinberg said, and workers taking applications were overwhelmed and probably forgot instructions about identification. Most of the auto-enrollment cases have been resolved, she asserted. Ms. Maves countered that auto-enrollment issues are as recent as two weeks ago, and those disenrolling must wait until the following month for it to take effect. Many of the auto-enrolled did not receive notice of the 90-day opt-out window, and there was no FFS option indicated on state plans, Ms. Maves said. A discussion commenced about the role of Xerox, which manages the CC call center, and about incorrect information given out to consumers who call asking to disenroll. Ms. Weinberg said the state's ASPEN system determines eligibility and contains demographic information. If the enrollee's information does not indicate "Native American", that person will be auto-enrolled in an MCO. A bureau in her division can change the race code, and she said she will try to correct Xerox's misinformation.

*Compensation to tribes for care coordination.* Ms. Weinberg reiterated that there are no plans to reimburse for care coordination in any FFS environment. Asked by a member if this is a federal rule, Ms. Weinberg said she did not think that there is anything in CMS regulations that would prohibit such payment.

*Explanation of federal Office of Management and Budget (OMB) reimbursement for FFS.* The IHS and tribes get the OMB rate from the state, which is \$330, inclusive of a physician visit, lab work, etc., Ms. Clark said. If a Native American is seen at a nontribal facility, the match is 70 percent. Ms. Weinberg said the reimbursement rate is 100 percent for adults in the Medicaid expansion. Any services delivered at a tribal facility are reimbursed 100 percent. MCOs pay this and pass along the invoice to the state, which then pays the MCO 100 percent of the tribal invoice.

*Need for legislation.* A committee member noted that in light of the CMS denial to the HSD, the choice of a Native American should be promoted rather than corrected. There should be systems in place to promote this choice without being administratively burdensome, the member stated. This issue keeps coming up with no resolution, and perhaps legislation is needed. Health care is a huge industry, the member continued, and tribes are trying to develop their own services. In a small community, people are used to going down the street for care and information; having a company located far away is burdensome to both the individual and the community.

### **Psychiatric Medication Oversight for Children in Foster Care**

Krystal Goolsby, president of Leaders Uniting Voices Youth Advocates of New Mexico and a graduate of the state's foster care program, told committee members that her advocacy group discussed medication at a meeting last week. Young children who come into the foster care system are already traumatized and are naturally more "hyper" in their behaviors, Ms. Goolsby explained. Children are given medication, and if one does not work, another is prescribed. One member of her group was on 16 different medications by the time she was old enough to understand; now she is on only three. Another group participant said his medications make him "feel like a zombie". Although the age of consent in the system is 14, Ms. Goolsby said, any youth in foster care should have a relationship with the prescribing therapist and a voice in the choice of medications. Describing her time in a residential treatment center, Ms. Goolsby said she was never asked how medications affected her, and anyone refusing medication was classified as noncompliant. Most of the young people hate taking their medications, she said. Now, Ms. Goolsby said, she sees that many of her friends need help, but because of their experiences, they refuse to take medications that could help them.

Thomas I. Mackie, Ph.D., assistant professor at Tufts Medical Center in Boston, thanked Ms. Goolsby for sharing her story. Dr. Mackie has been investigating the use of psychotropic medications in children for the past six years. The use of these medications can alter the mental health of a child, Dr. Mackie said, and research lags behind prescribing trends (see handout). There has been an exponential increase in the use of these medications prescribed for emotional

and behavioral disorders in children, and particularly in preschoolers, Dr. Mackie said. These trends, and the lack of research to support current practice, have important implications for work with traumatized children. Adolescents represent 25 percent of the Medicaid child population and 60 percent of total behavioral health expenditures. The use of psychotropic medications in Medicaid-enrolled children grew 62 percent in five years (2002 to 2007). In New Mexico, the concurrent use of three or more classes of psychotropic medication in children grew by nearly 35 percent during the same five-year period. Multiple studies have shown that provider shortages, lack of access to effective non-pharmacological treatments and gaps in coordination and continuity of medical and mental health care may play a role in these patterns of psychotropic medication use in foster children, Dr. Mackie said. Federal laws passed since 2008 now require more oversight and coordination, including screening, monitoring, use of more professional expertise, informed consent and sharing of information and decision-making. Dr. Mackie described varying state responses to these changes, and he urged legislators to review those listed on page 26 of his handout, especially noting the Ohio Minds Matter web site as a good example. Acquiring more mental health expertise for the state is critical, Dr. Mackie said, especially for those with child psychiatry expertise.

Jared Rounsville, director of the Protective Services Division, CYFD, described a newly formed council that includes Dr. George Davis, who is a child psychiatrist, and consumers. The council works with CYFD staff around the use of psychotropic medications in New Mexico. It has become clear that using these medications to mask trauma in children is not the most effective treatment, Mr. Rounsville said, and the CYFD has a deep and compassionate desire to change this. The CYFD is also training foster parents on this topic, using Dr. Bruce Berry's trauma academy and his neurosequential model of brain development.

On questioning, Ms. Goolsby, Dr. Mackie and Mr. Rounsville discussed with committee members the following topics.

*Challenges with lack of providers.* Mr. Rounsville admitted that finding and recruiting educated staff is a challenge, especially in rural areas. He said there are approximately 50 child psychiatrists in the state, but not all of them are practicing, or they are practicing part time, and most are in the Albuquerque area or at the University of New Mexico (UNM). Others who are prescribing psychotropic medications for children include psychiatrists who treat adults, pediatricians, nurse practitioners and physician assistants.

*Lack of data.* There are about 2,200 children in foster care in New Mexico, Mr. Rounsville said, and the CYFD does not know how many are on psychotropic medications. A member asked about babies being placed on psychotropic medications in foster care, and Dr. Davis responded that there are very few babies on these medications, but there has been a rise in medications for children under age five. The CYFD is working with the MCOs to find out how many Medicaid-recipient children are on these medications. Daphne Rood-Hopkins, director, Community Outreach and Behavioral Health, CYFD, spoke from the audience to assure committee members that the data have been requested and that the HSD has been very responsive

and will provide those numbers soon. There was a data dump by OptumHealth when it left the state last year, she said, but the CYFD is not getting a report on a regular basis. A member suggested that what is needed is a central registry like the one the state created for opiate prescriptions, and she would request and sponsor such a bill for pharmacists. A registry would work for everyone, the member asserted, and would not be politically sensitive. She also noted that, with the majority of behavioral health providers shut down by the HSD in 2013, there are no data available for how many consumers were on psychotropic medications at that time and where they are now. The member told Mr. Rounsville that she wants the information from the OptumHealth data dump to be provided to the committee. Another member asked Mr. Rounsville for data from the CYFD's Juvenile Justice Division, as well.

*Who makes the decisions?* Mr. Rounsville said it is the intention of the CYFD to intervene on behalf of children in foster care in a much more aggressive way to reduce the use of medication and provide trauma-informed therapy. Dr. Mackie pointed out that there are many good resources available about alternatives to medication. Another member noted that if there is nothing in MCO contracts requiring MCOs to follow the steps of treatment laid out by the CYFD, medication will always be the cheaper choice for them.

#### **2014 Senate Joint Memorial 14 Report: Grandparents Raising Grandchildren**

This memorial tasked the CYFD to work with the HSD and the Public Education Department to study issues affecting grandparents raising grandchildren, including custody and guardianship, financial resources, availability of legal services, food and housing assistance, medical care, transportation and community-based support organizations (see handout).

Mr. Rounsville provided a history of legislative efforts to assist kinship caregivers and a history of agencies that can assist in identifying legal issues that need to be addressed, including enrollment in public education. Since October 2006, the Aging and Long-Term Services Department has contracted with Pegasus Legal Services for Children, in conjunction with Law Access New Mexico, for this purpose, and it has provided legal assistance to 3,325 families, averaging 536 families a year and providing outreach and education to more than 7,256 individuals annually. Mr. Rounsville said that the CYFD provides training to relatives about resources and services and always attempts to identify relatives that are caregivers for children who otherwise would be placed in foster homes.

Today, there are 54,638 grandparents in New Mexico who are serving as heads of household for 52,098 grandchildren, according to the most recent American Community Survey of the U.S. Census Bureau, with a slight trend toward multigenerational households that can offer greater financial stability. Access to public benefits vary but are higher in multigenerational households than in those with grandparents raising grandchildren. Thus, the greater need for assistance is with this latter group, Mr. Rounsville pointed out. Other trends that emerged from this survey include an increasing number of grandparents over the age of 60 who are raising grandchildren, more children between the ages of 12 and 17 who are being raised by grandparents for more years and an increasing number of grandchildren under the age of two

being raised by grandparents. There is disparity among ethnic groups: 57.4 percent of these families are Hispanic; 24.4 percent are Native American; and 14.8 percent are white. Finally, he said, while the number of grandparents with disabilities has declined, the number of grandparents who are still employed is on the rise.

Financial resources include the HSD's Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program and other emergency food and energy assistance and the CYFD's child care subsidy programs. Community resources include Las Cumbres Community Services, Engaging Latino Communities for Education (ENLACE) New Mexico, the Adelante Development Center, Inc., and AARP New Mexico. Promising practices can be found at the Edgewood Center for Children and Families in San Francisco, which supports an extensive online one-stop shop for caregivers and public policymakers; Kinship Services Network at The Children's Home, Inc., in Tampa; and subsidized guardianship programs that support kinship caregivers in Florida, Louisiana and Missouri.

### **Grandparents Raising Grandchildren**

Elizabeth McGrath, an attorney and the executive director of Pegasus Legal Services for Children, described the difficulty of access to legal services for many grandparents. Her organization provides advocacy services in uncontested cases, but her organization has a long wait list, and she emphasized the need for additional funding from the state. A big problem is that access to information about a case often comes too late to affect the outcome. Ms. McGrath said that many children do not have a voice in the disposition of their own cases, and she would be willing to work with committee members on a remedy for this issue.

Rex Davidson, executive director of Las Cumbres Community Services, spoke of the sacrifices that many grandparents make, and he urged school systems, many of which are not well-versed in children's rights to education, to do a better job. Erwin Rivera, community resource/family specialist for ENLACE, pointed to audience members who are grandparents raising grandchildren and asked them to tell some of their stories. It is very difficult for a grandparent to negotiate a complex educational system without help, Mr. Rivera said. ENLACE, which also needs increased funding and support, could be a model used around the country. Testimony from grandparents raising grandchildren included one grandparent who said that food insecurity remains a big issue for her, as does housing and clothing. A grandfather who took in two young granddaughters said he had the support of CYFD training and Las Cumbres Community Services, but he does not qualify for financial services because he has a job. Now, 11 years later, his granddaughters' father and mother are doing better.

### **Mental and Behavioral Health Programs and Services Available to Native Americans**

Wayne W. Lindstrom, Ph.D., director of the Behavioral Health Services Division (BHSD) of the HSD and chief executive officer (CEO) of the Interagency Behavioral Health Purchasing Collaborative, described the vision and responsibilities of the collaborative, the role of the Behavioral Health Planning Council (BHPC) and local collaboratives, and the statewide managed care plan implemented with CC in January (see handout). He then introduced Barbara

Alvarez, BHSD tribal liaison, who detailed non-Medicaid provider programs for Native Americans totaling more than \$1.5 million (see spreadsheet). The funds and grants cover a wide range of services, including treatment of domestic violence, traditional Native American counseling, substance abuse, pregnant women with substance abuse, detoxification, treatment of veterans using western and traditional interventions, access to housing, prevention of homelessness, education for healthier lifestyle choices, a framework to help reduce underage drinking and a small grant to The Life Link to provide ad hoc invoicing based on cost reimbursement on behalf of the Native American subcommittee of the BHPC. Dr. Lindstrom told members that he plans to have data on what kind of services are being delivered to Native Americans through CC the next time he appears before the LHHS.

Arturo Gonzales, Ph.D., is executive director of the Sangre de Cristo Community Health Partnership and implementation director of Clinical and Partner Site Implementation and Sustainability of the New Mexico Screening, Brief Intervention and Referral to Treatment (SBIRT) program. SBIRT is an evidence-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and illicit drugs. It is currently used in primary care settings at partner sites, including the First Nations Community Healthsource in Albuquerque, the Pueblo of Jemez medical clinic, the Taos IHS medical center, the Acoma-Canoncito-Laguna Hospital, the IHS unit in Santa Fe and the trauma center at the UNM Health Sciences Center. Citing the significant success and cost savings of SBIRT's impact in New Mexico since 2003, Dr. Gonzales urged members to help implement the program statewide as part of the New Mexico behavioral health plan and to enable sustainability by ensuring activation of the Healthcare Common Procedure Coding System and Medicaid codes for billing.

Bret Smoker, M.D., chief medical officer of the IHS hospital and clinics in Santa Fe, reported on Native American health disparities: Native Americans experience twice the national average of substance abuse and twice the national average of suicides. SBIRT has been very well-accepted and is valued in the IHS hospital and clinics, including by clinical staff, Dr. Smoker said. It is a very effective intervention and normalizes these issues by integrating the screening into primary care. Leslie Dye, CEO of the Santa Fe IHS unit, said she, too, is very excited about the SBIRT program, adding that nearly everyone has been touched by these issues. Keahi Kimo Souza, behavioral health director at the Pueblo of Jemez Health and Human Services Department, said he is committed to SBIRT helping to address many health challenges, but funding is a big issue. Help still is needed with billing, but the Pueblo of Jemez is honored to be chosen as an implementation site. SBIRT's model of using a behavioral health therapist and peer support worker in the initial stages of brief treatment provides a warm hand-off when further professional help is warranted.

On questioning, Drs. Lindstrom, Gonzales and Smoker and committee members discussed efforts to expand SBIRT statewide. A member questioned the cost shift that can occur when billing codes are added. Dr. Lindstrom said that if this service is added, and if it has to have federal approval, there can be an actuarial cost, and MCOs would be looking for a greater capitation rate. This kind of service is a short-term increase in costs, he added, but long-term

reduction of costs is not part of the Medicaid budget. Another member thanked Dr. Gonzales for his efforts and for coordinating, and doing training for, a single system to help sites provide a service that is especially crucial for rural areas. Dr. Gonzales said today's appeal to the committee was his "last hurrah". In hearings, the HSD testified against the program, he noted. The IHS believes in this program, and UNM believes in it, he said. Dr. Lindstrom, when questioned by committee members, said the BHSD is highly supportive of SBIRT.

### **Recess**

The committee recessed at 5:48 p.m.

### **Tuesday, October 21 — State Capitol, Room 307**

#### **Welcome and Introductions**

Senator Ortiz y Pino reconvened the meeting at 9:22 a.m., noting that Representative Madalena would be unavoidably late. He welcomed legislators and guests and asked staff members to introduce themselves.

#### **CC Long-Term Care; Home- and Community-Based Services (HCBS); Community Benefit; Self-Directed Services; Independent Consumer Supports System; Care Coordination; Alternative Benefit Package**

Ms. Weinberg told members that CC's innovative Medicaid model has put New Mexico in the spotlight, and other states are watching closely for outcomes. Currently, New Mexico has approximately 729,000 individuals enrolled in Medicaid, which includes Medicare premium-only programs. There are 575,000 people enrolled in CC, with 171,000 of those from the state's Medicaid expansion (see handout). Long-term services and supports in CC include nursing home care and HCBS through the community benefit, which can be agency-based or self-directed. To be eligible for the community benefit, an individual either must be Medicaid-eligible, either financially or due to disability, or not otherwise eligible for Medicaid but eligible for institutional-care Medicaid. The first group is now entitled to full HCBS; individuals in the second group must have a waiver slot to obtain services. There are now more than 14,000 individuals with expanded access to HCBS, Ms. Weinberg said, and the CMS has authorized 4,289 waiver slots in New Mexico, 2,945 of which are currently filled. It is anticipated that another 800 slots will be filled by the end of fiscal year (FY) 2015. There are approximately 15,000 individuals on the wait list, Ms. Weinberg said, but some do not qualify and many others do not respond when contacted. Some people put themselves on the registry because they think they might eventually need it, she said. Priority is first-come, first served, except for nursing home residents who wish to return to the community.

Care coordination is at the heart of CC, according to Ms. Weinberg, and follows a health risk assessment (HRA) conducted on every member by the MCOs to address needs and goals. Currently, the MCOs report that about 50 percent of their members have been assessed; a member cannot be forced to undergo an HRA. Expansion adults are under CC's alternative benefit plan (ABP), which includes a wide array of physical, behavioral and dental health

services and may require nominal co-payments for certain services, depending on income. It does not include long-term supports and services, and a medically frail individual can choose to become ABP-exempt to access these. Others with conditions such as pregnancy, serious mental illness, chronic substance use disorder, a terminal illness or other serious illness may also opt out of the ABP due to its limits on the extent and duration of various therapies.

William Orr, M.D., told members that UnitedHealthcare Community Plan of New Mexico has intensive coordination of care so that individuals can be transitioned across physical and behavioral health systems of care. With regionally based blended teams, services now can be integrated. Needs assessments are done in the member's home, with a focus on education and data-sharing, Dr. Orr said.

Molina Healthcare of New Mexico uses a person-centered, integrated-care approach, according to Cathy Geary, director of health care services and a nurse with many years of experience with the medically frail. Care coordinators are advocates who help people navigate a complex health care system. Ms. Geary said she has been involved in many Medicaid rollouts, and CC is the most complex she has seen. Maintaining an interdisciplinary team of providers for physical and mental health is very important to the plan, Ms. Geary said. The HRA is done in a member's home, and community health workers and peer-support specialists are on board as part of the community connection. Molina operates in 14 states, and Medicaid is its only business.

Charles Milligan, an attorney and senior vice president for enterprise government programs, Presbyterian Health Plan, Inc., spoke of the company's need to be nimble with care coordination plans that can change as members' needs change. The Presbyterian model includes a hub of services and nonmedical supports. Mr. Milligan described four dimensions of integration: (1) between physical and behavioral health needs; (2) between Medicaid and Medicare (for members who are dual-eligible); (3) between home-based and institutional care; and (4) between acute care and community-based services and supports. Home visits to members are critical to the planning process, he said.

Sharon Huerta, CEO of Blue Cross Blue Shield New Mexico (BCBSNM), told members that her company exceeds its contractual requirements for CC. Multiple contacts are usually required to conduct an HRA in a member's home, and the company uses promotoras and community health workers on the ground in the community. While the majority of members fall into the lowest level of need for care coordination, BCBSNM makes a robust effort to assess, and assist in, members' evolving needs.

### **User Advocacy Panel**

Jim Jackson, executive director of Disability Rights New Mexico (DRNM), said that CC holds promise for the elderly and disabled, with expanded long-term-care services and a diverse menu that should provide for everyone's needs if program elements are in place, functioning and working together. However, DRNM's experience is quite different from what has been presented, he said, and many barriers remain (see handout). Mr. Jackson maintained that nearly

10 percent fewer persons are being served now than this time last year under the previous Coordination of Long-Term Services (CoLTS) program. He questioned why waiver slots have not been filled, and he pointed out that the state gives preference to individuals in a nursing home who want to access HCBS, creating an incentive to go into a nursing home to bypass the nearly 16,000 people on the wait list. This issue is not new to CC, but it is a continuation of a state policy, he said, not a federal requirement.

Claire Dickson, a staff attorney with the nonprofit Senior Citizens' Law Office in Albuquerque, said that care coordination, a lynchpin of CC, should be robust; it is the right time and the right place, and it is written into contracts with the MCOs. While care coordination should help consumers with the complicated navigation of CC, this is not necessarily happening, she said. Ms. Dickson offered three cases of different consumers who were unable to access a care coordinator or whose cases were simply dropped from any assistance. These cases and others at the office have made Ms. Dickson concerned about the level of knowledge of care coordinators.

Sandy Skaar, owner and director of Self-Directed Choices, LLC, a support broker agency for the self-direction community benefit option under CC, described many MCO members who have not had their initial assessments; members who were on the Mi Via self-directed home- and community-based waiver services program under the CoLTS "c" program for brain injury services program prior to the implementation of CC who now are having their budgets cut; and numerous problems with care plan approvals and appeals (see handout). Ms. Skaar also expressed concern about an apparent lack of expertise among care coordinators and frequent turnover among personnel. The goal of community reintegration has helped many New Mexicans leave nursing homes and live safely in their communities. Now, budget cuts might force them to return to nursing homes, and Ms. Skaar asked if this is what is wanted for fellow New Mexicans.

Ellen Pinnes, a lawyer and consultant to the Disability Coalition, discussed details of the ABP for new Medicaid enrollees. Under the federal Patient Protection and Affordable Care Act (ACA), states could align their "expansion" adults under traditional Medicaid or under the ABP. Most states have chosen the former; New Mexico chose the latter (see handout). Ms. Pinnes described some differences between traditional Medicaid and the ABP in New Mexico, including different benefits, co-payments and the fact that the ABP does not include long-term services. According to federal regulation, persons who are medically frail or who have serious mental disorders, complex medical conditions, disabilities or chronic substance use disorders are exempt from the ABP. Ms. Pinnes said she could not find a definition of these individuals in CC or in the state's Medicaid program manual. According to the HSD, as of July 31, approximately 160,000 newly eligible adults had enrolled in Medicaid, and only 270 of these had been determined to be ABP-exempt. She said she cannot understand why this number is so low. All expansion adults are automatically enrolled in the ABP, and exempt individuals must opt out. This is contrary to federal requirements, Ms. Pinnes said, asserting that the HSD's approach to

this issue creates barriers to long-term services for newly eligible seniors and people with disabilities.

Guy Surdi, a disability specialist and member of the Governor's Commission on Disability, presented brochures from the New Mexico Independent Consumer Support System with phone numbers, resources and links (see handouts) and supplied members with a copy of the CMS "Special Terms and Conditions", which describes the federal requirement for independent consumer supports to assist enrollees in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights (see handout). The system should provide consumers with comprehensive information regarding their benefits and help identify the appropriate services needed, but New Mexico's system is not very consumer-friendly, Mr. Surdi said, and does not provide any understanding of benefits. He has heard many complaints from consumers about how difficult and frustrating it is to contact CC. Progress on this system has been slow, Mr. Surdi said, and with minimal resources, there are no plans for local counselors and no contacts for independent living centers. His recommendation is to initiate robust outreach using local organizations to provide assistance.

On questioning, panel presenters and committee members discussed the following topics.

*Ratio of care coordinators to members.* The ratio of care is uniform throughout the state, Ms. Weinberg said. The ratios are: one to 750 for Level 1; one to 75 for Level 2; and one to 50 for Level 3. These ratios are set out in the MCO contract. A panelist noted that one of the challenges is that care coordinators are required to be employees, and this accelerates the cannibalizing of providers. Ms. Huerta said that the care coordinator ratio for those in nursing homes is one to 125; it is one to 140 for self-directed members.

*Care coordinator safety.* Care coordinators are required to travel, given the rural nature of the state, one member noted, but she has heard complaints that some are afraid to enter members' homes, perhaps due to a member's behavioral health issue. All care coordinators receive safety training, representatives of the MCOs explained, and none is required to enter an unsafe situation. They can travel in pairs, with a supervisor or another coordinator, and can request an exception from the HSD. Care coordinators are required to have a bachelor's degree and at least two years of experience in social services, Ms. Weinberg added. They are also specially trained by the MCOs. She admitted that there may be a breakdown in training on eligibility, and she has made note of that as well as of possible issues with computer systems.

*Behavioral health services that are excluded from the ABP.* Ms. Weinberg said she does not know what those services are or how many newly eligible consumers have access to behavioral health services, but all necessary services are available to new enrollees through either the ABP or the state plan. If they need those services, they are ABP-exempt, she said. The MCOs are required by contract to deliver those services while they process the exemption. Ms. Pinnes stated that there are three services excluded from the ABP: (1) peer support; (2) respite support; and (3) family support. Another member noted that MCOs are turning down

reimbursement-of-care coordination or services that are not provided by a core service agency, of which there are only a few. Ms. Weinberg asked members to call her if they hear about someone who should be getting services but is not. A panelist urged a more robust independent consumer support system and more help for people trying to navigate. The resolution of "call Julie" is not robust enough, he said.

### **Long-Term Services Consumer Panel**

Dorothy Danfelter said she has a stepson with brain injury and has had continuing problems with care coordination and an insufficient level of services. Her stepson is 36, had an accident at age 22 and has anger-management issues. She has received \$2,800 in co-payments for medication, and she appreciates this program. Her stepson can live at home and lead a somewhat normal life, but care coordination is complicated.

Doris Dennison said she was on Mi Via and was very happy, but she is now in CC with Molina and is having problems accessing and coordinating her health care services. She started receiving denials for services, and her medical supplies were cut. Ms. Dennison said her care coordinator has been changed twice, and she still has not received an assessment. Transportation over long distances is a big problem, and mileage reimbursement is now lower. She was not advised that she could, as a Native American, opt out of CC. Ms. Weinberg noted that anyone who needs long-term supports and services must be in CC, including Native Americans.

Deborah Cooper said her husband is a brain injury survivor. Brain Injury Services Fund money will run out soon, and she does not think he will qualify for long-term services. Ms. Cooper said she has worked as a brain injury advocate and resource facilitator and took training at her own expense. Now, under CC, she has had a cut in pay for helping others because community direct support is no longer a supported code. Ms. Cooper is a founding member of New Mexico's Rural Coalition/Coalición Rural, and she has a son who is disabled with behavioral health symptoms. She is responsible for a household of three but cannot afford insurance for herself. One of her clients was not able to get the services he needed and now is in a nursing home.

Ed Keller said he has a severe brain injury. He said a care coordinator "looks good on paper", but he knows a nurse who lives in Las Vegas and has a caseload of more than 100 people. After a three-hour assessment, he was assigned to Level 2, and a budget was supposed to be set up as of August. Now he has been assigned a new care coordinator and was told that because it had been more than 90 days since the last one, he has to have a new assessment. Mr. Keller said he got a laptop computer but could not get an insurance policy for it. Now, if he drops the laptop, he will not be able to get a replacement. His new care coordinator does not seem to know what she can put in his budget, which is to start December 1. "These shifting sands are intense", he said. "These are people's lives."

Ms. Weinberg was asked by a committee member if the amount of funding available for Mi Via clients was reduced under CC. She responded that funding did not get reduced, but the

benefit cannot exceed the average cost of a nursing home (\$56,500). Those already in the program who had higher budgets were grandfathered in, she said. If a consumer's needs change, then the budget might change. MCOs that want to reduce budgets have to get approval from the Quality Bureau of the HSD, Ms. Weinberg said. Only 10 requests have occurred, she said, and just two have been granted. Mr. Keller said he was told the previous week that his entire budget was up for review regardless of what it was last year. Ms. Weinberg said she does not understand why he would have been told this. The committee member urged Ms. Weinberg to help the consumers who appeared before the committee today, and she agreed to do so.

### **Program of All-Inclusive Care for the Elderly (PACE)**

Beverly Dahan, vice president of government and legislative affairs for New Mexico PACE, said the program provides comprehensive health services for individuals age 55 and over who are sufficiently frail to be categorized as nursing-home eligible by their state's Medicaid program. There are currently 106 PACE programs in 31 states (see handout). InnovAge (formerly Total Community Care) is the only PACE provider in New Mexico, Ms. Dahan said, and serves nearly 400 participants in Bernalillo, Sandoval and Valencia counties.

Irene San Roman, M.D., medical director of InnovAge Greater New Mexico PACE, said the program's comprehensive approach to care for the elderly offers an alternative to nursing home care. Clients are able to receive the support and services they need to allow them to stay at home, maintaining their dignity and independence. InnovAge provides a multitude of professional and social services, primary and specialty care physicians and adult daycare and health center services, and it is reimbursed on a fixed per-member, per-month rate by both Medicare and Medicaid. There are no co-payments, premiums, deductibles or service limits, Dr. San Roman said. Citing several different cases, Dr. San Roman said that the program saves money in the last six months of life, and it also supports families by allowing them to continue to work.

A committee member asked if the program is new. It was set up by the federal Balanced Budget Act of 1997, Ms. Dahan said, and was operated for many years in Santa Fe by St. Joseph's Hospital. New Mexico is now capped at 400 and has a wait list. The state does put up matching dollars for the program. InnovAge has approximately 2,400 clients in Denver and Pueblo, but it is a very challenging program to try to put in rural areas. Another member asked about the savings to the state. Ms. Dahan said studies have shown that it saves 20 percent in the last three years of life and 60 percent in the last six months of life. A member whose great-grandmother spent her last two years of life in the PACE program said it gave her grandmother dignity.

### **Nursing Home Reimbursement Rates**

Linda Sechovec, executive director of the New Mexico Health Care Association (NMHCA), provided background on her organization's \$3.5 million request for FY 2015, \$2 million of which was approved — a 3.65 percent rate increase for nursing facilities (see handout). The new rates were effective July 1 but were not loaded by MCOs until late

September. Most of the claims back to July 1 have been approved for payment, but some are still pending, she said. This appropriation has been critically important because of the negative impacts that came with the implementation of CC, she said, including the state's decision to change level-of-care criteria, resulting in a projected decrease of \$30 million in Medicaid payments. There also have been problems with MCO nonpayment of claims, delayed level-of-care determinations, backlogs in eligibility determinations and payment delays. Ms. Sechovec said that the change in criteria to restrict patients who qualify for "high" nursing facility services was made with minimal input from providers and no consideration of the financial impact to the industry. In October, her organization created a model to project that impact: \$30 million annually in losses to New Mexico facilities. This change in the criteria has threatened facility solvency statewide, Ms. Sechovec asserted, causing a reduction in staffing and services and halting capital improvement programs to upgrade facilities and equipment. Facility margins of operation are now in the negative.

A committee member asked Ms. Sechovec how her members stay afloat. Most of her members are being supported by national entities, she explained, but corporate executives have been calling, asking what is going on in New Mexico. New rates must be negotiated, she said; it is critical that all entities move forward together and find a solution. Her calculations show more than \$16 million is needed from the state.

### **Long-Term Services Provider Panel**

Anna Otero Hatanaka, executive director of the Association of Developmental Disabilities Community Providers (ADDCP), told committee members that she is urging that \$15 million be appropriated, \$5 million each to the Family Infant Toddler Program, the developmental disability (DD) state general fund and the DD Medicaid waiver program. The situation is dire, she warned. Several large providers have dropped supported employment, and Goodwill Industries no longer will provide DD waiver services. LEADERS Industries in Lea County, which has been in business for over 40 years, is closing down altogether, Ms. Hatanaka said. With the oil and gas boom in the southeastern part of the state, LEADERS cannot find staff to compete with energy industry salaries. Provider agencies are currently working under "survival mode" conditions due to rate cuts and the lack of predictable annual rate increases (see handout). Her members assert that developmental delay and disability service systems in the state are unsustainable due to increasing unfunded mandates and the absence of any rate increases. The ADDCP is asking the legislature and the Department of Health (DOH) to: (1) recognize that current provider rates do not cover costs of services, mandates and expectations; (2) reduce unfunded mandates through revisions to regulations and service standards; (3) provide for annual cost-of-living increases; and (4) reimburse at rates that actually meet the costs of operations and compliance required to sustain the service systems.

Bobby LeDoux, director of Citizens for the Developmentally Disabled in Raton, a member organization of the ADDCP, told committee members that between 2009 and 2014, his organization lost a total of 24 percent of its annual revenue, with a five percent additional loss anticipated by the end of the year. There used to be an expectation that there would be "light at

the end of the tunnel", he said, but such a belief is no longer possible; it just gets worse and worse. Mr. LeDoux is highly critical of the continuing costs of the *Jackson* lawsuit in a community like Raton, which "has lost everything" in the economic downturn.

Mike Kivitz, president and CEO of Adelante Development Center, Inc., in Albuquerque, provided members with a fact sheet highlighting financial issues for his nonprofit organization (see handout). He pointed out that rates lost 17 percent purchasing power versus the Consumer Price Index between 1999 and 2010. A five percent rate reduction in 2011, combined with an eight percent reduction in the annual resource allotment for each consumer, has resulted in an \$18 million reduction in waiver spending systemwide. In May 2013, further reductions in rates were implemented, he said. During the last 14 years, standards, regulations and other directives have exploded, Mr. Kivitz said, resulting in a DD provider system that is not sustainable. Providing waiver services is a dying business, he said. Adelante has had to shut some services; it has closed one location and is looking to get out of supported employment altogether. Mr. Kivitz said he wants to make an economic development plea for jobs in New Mexico: 75 percent of his budget goes for salaries and benefits for staff.

Panel presenters and committee members discussed the need for a new rate study. This is a disastrous situation, a member stated, adding that in a panel presentation on this topic at the Disabilities Concerns Subcommittee, she was appalled that, with 10 of 15 behavioral health providers shut down, no one had any information on what happened to the shuttered agencies' clients, what amounts of funding had been withheld from them, where those funds are being held now and if they are earning interest. Hopefully, the LHHS can get OptumHealth to provide the committee with some answers, the member concluded. Another member asked if a Legislative Finance Committee (LFC) analyst could present recommendations on rate increases at the next meeting of this committee. The chair assured the member there would be follow-up. Ms. Hatanaka reminded committee members that the \$500,000 raise for DD waiver providers scheduled for July 1 still has not been implemented by the HSD.

### **Public Comment**

Rebecca Shuman, operations manager and self-directed community benefit (SDCB) support broker at AAA Participant Direction in Albuquerque, provided committee members with a detailed presentation (see handout) of how members transitioning from Mi Via are having their services reduced and how new members are having services denied. Overall, CC's SDCB members are experiencing an alarming rate of long-term care service reductions (12 percent) and denials (20 percent), Ms. Shuman asserted. The MCOs have been using agency-based reimbursement rates rather than self-directed rates, and the computer program required for use by consumers blocks requests for service or requires a reduction in hours. Because the request does not go through, no letter of denial is sent by the MCO, and the self-directed client is unable to appeal the decision or apply for a Medicaid fair hearing. Ms. Shuman urged that MCOs be blocked from using agency-based rates for self-directed consumers, that Xerox make changes to its online program so that no request for service from a self-directed client is blocked, that self-directed clients be allowed to appeal any decision with or without a notice of action letter and

that hearings be provided to all self-directed members, whether they have exhausted the MCO appeal process or not. Ms. Shuman maintains that many traditional health care professionals working at MCOs do not understand the purpose and benefits of self-direction.

Ken Collins, formerly from Oregon where he was a semiprofessional baseball player, identified himself as brain-injured from a snowmobile accident and said he has been a presenter the last four years at the statewide disabilities conference. Mr. Collins provided written materials related to his comments (see handouts). Although his brain injury occurred more than 30 years ago, Mr. Collins reported that the use of biofeedback, neuroplasticity and mindfulness therapies have provided him with dramatic improvement over the last three years. After listening to the day's committee testimony, it is his opinion that the MCOs are creating stress, not solving it.

John Noel, director of staff development at A Better Way of Living in Albuquerque, said his agency may be closing its employment services. Mr. Noel said that he has seen a drastic reduction of funding and an increase in regulation for supported employment. Having a job provides an individual with a hand up, not a handout, and he urged the state to practice what it preaches.

#### **Recess**

The meeting recessed at 5:11 p.m.

#### **Wednesday, October 22 — State Capitol, Room 307**

#### **Welcome and Introductions**

Representative Madalena reconvened the meeting at 9:06 a.m., welcomed those assembled and asked committee members and staff to introduce themselves.

#### **Update: Medicaid Credible Allegations of Fraud**

Knicole Emanuel, an attorney with Williams Mullen in Raleigh, North Carolina, and a specialist in Medicare/Medicaid compliance litigation, spoke in favor of Senator Papen's proposed legislation amending the Medicaid Provider Act. The search for fraud has become overzealous, Ms. Emanuel asserted (see handout). The ACA requirement that the state Medicaid agency "must" suspend payments to a provider with a "credible allegation of fraud" (CAF) is a very low standard for such drastic consequences, basically putting that provider out of business, Ms. Emanuel said. The impact is especially difficult in rural areas when staff members become unemployed and the entire community is adversely affected. The investigative process for a CAF must not infringe on the legal rights of providers, and it must afford due process, she said. Federal law relies on the states to provide due process, but this was not done in New Mexico.

Ms. Emanuel said Senator Papen's bill requires a CAF to be "verified", meaning the totality of facts and circumstances must be considered. Prior to determining the existence of a CAF, the state must use auditors who are licensed and credentialed, provide written notice of tentative findings, explain specific allegations and allow correction of clerical errors. Senator

Papen's bill includes additional remedies for providers: judicial review and injunctive relief with recovery of attorney and witness fees if the judge finds that a department has acted arbitrarily or capriciously, she said. Senator Papen's bill also allows for the return of suspended payments within seven days upon the posting of a bond by the provider pending final determination of overpayment or a determination by the attorney general that no further action is required. Ms. Emanuel cited examples from her own clients of fraud being alleged over simple mistakes in home health care, billing for a code that required prior authorization, a determination of "medical necessity" made by an unauthorized individual and inadvertent mistakes of gender or other typing errors. Typos do not equal fraud, Ms. Emanuel emphasized; fraud is an intentional act.

James Kerlin, CEO of The Counseling Center, Inc., for the past 20 years, said his company had been contracting with state agencies for most of its nearly half-century history and never had anything but satisfaction with its clinical billing systems, in-house audits and audits by the state entity, with scores that never went below 94. He asked members to try to imagine his shock upon discovering that the HSD had asserted a CAF against his company and stopped all Medicaid payments. His company was denied any information and was told that the CAF was now a criminal investigation. Mr. Kerlin said that if his organization could have seen what was being looked at by the HSD, it could find the problem and resolve it. The Public Consulting Group (PCG) audit was different than most, Mr. Kerlin said; PCG came in and left without any follow-up. The Counseling Center operated from June 24 until August 8 on reserve funds; on August 7, it was told that a transition to La Frontera would occur at midnight the next day. La Frontera hired all but four of its staff, and initially there was very little effect on the clients; but to be forced out of business was a tremendous shock and a professional insult, Mr. Kerlin said, and Alamogordo lost an important unifying element of the community. Mr. Kerlin urged committee members to support Senator Papen's bill mandating the due process that his company was not allowed. Bill Domiller, board president of The Counseling Center, spoke from the audience to add that the agency was shut down with no communication to the board of directors. The lack of due process is criminal, Mr. Domiller asserted.

Mark Johnson is CEO of Easter Seals/El Mirador, a Santa Fe-based nonprofit organization for children with behavioral health needs and adults with intellectual disabilities. His company was one of 15 New Mexico agencies accused of fraud by the HSD, and there was never any disclosure or due process. The PCG audit stated that it did not find evidence of any CAFs, and face-to-face meetings could have resolved these matters, Mr. Johnson said. The outcome was that the HSD spent \$24 million to replace providers, and Easter Seals lost \$4.5 million and had to lay off 40 employees. New Mexico's attorney general cleared his company of fraud accusations in May 2014, but the case was immediately re-referred by the HSD, Mr. Johnson said. His company is still owed \$700,000 for Medicaid services that were delivered.

Senator Papen prefaced a discussion of her bill with the fact that the Internal Revenue Service always tells a targeted individual or company what it is looking for. Her bill gives providers the right to know what they are being accused of, she said, and while it might not make a difference to the 15 agencies, it will make a difference in the future. There are 729,000 New

Mexicans enrolled in Medicaid, and the state's dealings need to be collaborative, Senator Papen said. The HSD suspensions did not improve mental health services in the state and ran counter to the creation of more jobs. Significant numbers of workers have been laid off, further disrupting the economies of many communities. To keep providers and attract new ones to the state, Senator Papen said, there must be greater transparency and guarantees of due process. She asked committee members to endorse her bill.

Ms. Mathis, who assisted Senator Papen in drafting her bill, described problems with the lack of precise or objective definitions of "credible", "verification" and "fraud" under current law. She then detailed the changes being proposed in Senator Papen's bill to sections of the Medicaid Provider Act and the Medicaid Fraud Act (see handout).

Upon questioning, presenters and committee members discussed the following topics.

*Who can make a CAF?* A member asked if legislation could be drafted to make the attorney general the entity responsible for making a CAF. Ms. Mathis said it was her understanding that under federal law, it is the department secretary who makes that determination. Ms. Emanuel concurred, adding that the state agency can contract with another entity, such as PCG, to conduct a preliminary investigation. In New Mexico, PCG found no evidence of fraud, she noted, but this finding was thrown out by the HSD. The member recalled that HSD attorney Larry Heyeck insisted that once a CAF is made, the secretary's hands are tied and she is required to suspend payments; this is mandated by the ACA. Ms. Mathis said that federal law does require payments to be suspended after a referral, but it also allows the suspension to be lifted, or partially lifted, for good cause; it is her understanding that all of the 15 agencies requested, but did not receive, a good-cause exception. The member said he is still puzzled at how two of the 15 agencies were able to buy their way out. Ms. Mathis explained that the HSD and the attorney general are empowered by law to settle on behalf of the state.

*Questions about power.* A member thanked Senator Papen for her bill and expressed outrage at what happened to the 15 behavioral health providers. He said he is stunned by the lack of legislative power to do anything. In his home community, one of those agencies, Hogares, delivered great services for more than 40 years, and he does not know why it has not filed suit against the state. Ms. Emanuel reminded committee members that most of the providers are now bankrupt, and it is costly to pursue a lawsuit. She said that the legislature does have power; in her state of North Carolina, the legislature passed a law giving itself more power and now reviews state agency action before it is taken.

*Coding errors.* A member whose husband is a physician and reviews medical codes every day said she appreciates this opportunity to pull out human error from the definition of fraud. This bill is a great first start, the member stated, and she hopes it will get some traction. The member also asked Ms. Mathis if Subsection D of Section 6 of the bill, regarding payment of fines for receiving a certain value of benefit, is for a single service or is an aggregate amount. Ms. Mathis said she would look into this.

*Continuing questions about HSD data and the role of OptumHealth.* A member noted that, recently, the HSD has claimed "more services are being given than previously". No claims data for the last six months of 2013 have been provided, Ms. Mathis noted, despite repeated requests from Senator Papen and the committee. A member was incredulous that \$27 million was spent in the transition to Arizona providers over that six-month period, yet there are no data. Another member clarified that the \$27 million was not for services; it was to facilitate the transition. OptumHealth was paid \$40 million to oversee the behavioral health system but has suffered no consequences for overlooking the alleged systematic fraud, the member continued. Ms. Emanuel said there are copies of the OptumHealth provider audits that show providers to be 95 percent compliant and doing a great job. Of the entities hired and paid by the taxpayers, none found fraud except the secretary of human services, she said. Another member pointed out that federal law mandates transparency, yet no one knows how much money is still in the hands of OptumHealth, whose contract was extended by the HSD in January without going out to bid.

*What constitutes real fraud?* Ms. Emanuel said that in her opinion, most audits are designed to uncover misbillings and miscodings, not necessarily systematic fraud. She has seen numerous cases of fraud, such as double-billing, billing services for recipients who are deceased and billing for services that were not rendered, among others. She does not think New Mexico providers were accused of these activities.

The committee chair thanked the panel participants and stated that, lacking a quorum, the committee could not vote to endorse Senator Papen's bill at this time.

### **Public Comment**

Martha Cook, a social worker and member of the National Alliance on Mental Illness (NAMI), said she has seen providers trying to accommodate all of the changes in care systems from Value Options to OptumHealth, and now CC, and it is devastating to acknowledge that the state has been punitive. She thanked Senator Papen for bringing this bill forward.

Deborah Walker, executive director of the New Mexico Nurses Association, described recent intensive training from the federal Centers for Disease Control and Prevention (CDC) for a comprehensive response to Ebola and said that providers at any access point should be able to screen for the disease. Her organization is happy to be a resource for legislators and constituents.

Ms. Pinnes, speaking as a private citizen, urged legislators to look into establishing a process to manage agency contracts over \$200,000. The state has an important role to play in protecting due process, and she strongly supports Senator Papen's bill. Recently, OptumHealth has been alleged to have engaged in fraudulent practices, and Ms. Pinnes wondered why the HSD has dealt with it differently than the 15 providers.

Jim Ogle, president of NAMI in New Mexico, said he found out in an email that Valencia County no longer has any behavioral health providers, and people now need transportation to Albuquerque to access services. This will put more pressure on the larger providers and will

cause more problems. Over the years, Mr. Ogle said, he has seen a decrease in the population at the Metropolitan Detention Center in Bernalillo County, but now more mentally ill individuals are being incarcerated at higher rates. He thanked Senator Papen for her bill, saying due process is important and it was denied to the 15 providers.

Written comments submitted by Charles Marquez, lobbyist for the NMHCA, were distributed by a committee member, reviewed the reimbursement rate crisis for the state's nursing homes and decried the lack of input from the member community regarding the HSD's decision. Mr. Marquez stated that the HSD eventually realized in July 2014 that its changes had, in fact, reduced reimbursement to levels well below estimates, and in August, discussions were begun to address needed changes, but the NMHCA has not heard anything more. One member company has nine facilities operating in the red, and another has six facilities in the red, according to Mr. Marquez, placing the industry at high risk for staff reductions and possible closures statewide. The nursing home industry is requesting that the LHHS bring the facts of this crisis to the attention of the LFC for action.

### **Basic Health Plan (BHP) Update**

Mr. Hely described the health insurance program for low-income individuals who do not qualify for Medicaid, including adults with incomes that are 138 percent to 200 percent of the federal poverty level and legal resident immigrants who are excluded from Medicaid for a five-year waiting period (see handout). Financing for a BHP will come from the federal government (95 percent of what it would have spent on tax credits and insurance subsidies), state matching funds and enrollee premiums. At least two plans have to be offered and put into place by January 1, 2016. The risk pool is kept separate from individual and group pools and must have an actuarial assessment, Mr. Hely said. The state must devise a blueprint with public and tribal consultation and establish a trust fund. The BHP will utilize a managed care model.

On questioning, Mr. Hely and committee members discussed differences between the BHP and high-risk pool. The BHP should be more affordable because there are no income restraints, Mr. Hely said. Federal law does not require statutory change, but it does require a blueprint. A member stated that if taxpayer dollars are being spent, statutory change is needed instead of regulations. The member asked Mr. Hely to prepare a memorial for a task force, naming the member as chair, for the December LHHS meeting. Because federal funds cannot be used for administration, costs to the state need to be minimized. BHP plans are called standard health plans, and premiums cannot exceed the cost of the second lowest silver plan on the New Mexico Health Insurance Exchange (NMHIX).

### **Medicaid Pediatric Dental Pilot Proposal**

Walter Bolic, CEO of Delta Dental of New Mexico, and Michael Wallace, director of government and corporate relations for the company, described dental utilization trends as they relate to Medicaid growth nationally and in New Mexico (see handout). The nonprofit Delta Dental of New Mexico has more than 350,000 commercial and retired members, Mr. Wallace said, and a problem has emerged for individuals who are below 400 percent of the federal poverty

level who are trying to access benefits but cannot find a provider. He then introduced Rick Lantz, manager of government relations for Delta Dental of Michigan, Ohio and Indiana, who described his company's partnerships with the Michigan Department of Community Health (MDCH).

Delta Dental of Michigan, part of a nationwide system, is the largest administrator of dental benefits in Michigan, providing coverage to more than 3.3 million members, Mr. Lantz said. Its partnerships with the state include Healthy Kids Dental (HKD) (Medicaid) with 540,000 members, MICHild (State Children's Health Insurance Program) with 32,000 members and Healthy Michigan Plan (Medicaid expansion program) with 236,000 enrollees. The MDCH identified barriers to dentist participation in Medicaid — insufficient reimbursement, administrative hassles and broken appointments — that have resulted in poor access to dental care for enrollees.

HKD was established as a pilot program in 22 counties between Delta Dental and the MDCH in 2000, serving Medicaid-enrolled children under the age of 21. Seven expansions over three administrations later, children in 80 of Michigan's 83 counties are now being served by the program, Mr. Lantz said. Enrollment is automatic, and enrollees can receive care from any dentist in the HKD network with no patient co-payments or annual maximums. Delta operates two main networks of dentists in Michigan: premier (93 percent participation) and the discounted preferred provider organization (PPO) (30 percent participation). The HKD program utilizes the premier network but pays according to the PPO fee schedule, using the same claims administration and payment system as for its commercial customers, with 97 percent of claims processed within 10 days, Mr. Lantz said. With multiple positive outcomes for enrollees, verified by independent evaluation, the cost is \$118 million per year for 540,000 enrollees \$40.6 million in state funds and \$77.4 million in federal funds.

Delta Dental of New Mexico has contacted state Medicaid officials about a possible pilot program, Mr. Wallace said, and there was interest but also concern about a potential increase in the administrative burden. Delta Dental is the largest insurer in the state, Mr. Wallace said, and would be able to deliver, overnight, access to dentists.

### **NMHIX Update**

Amy Dowd, CEO of the NMHIX, gave a presentation to committee members on the agency's plans for the upcoming enrollment period, starting November 15 (see handout). The estimated number of uninsured people eligible for tax credits is between 161,000 and 172,000 — over half of the total uninsured people in New Mexico, Ms. Dowd said. Changes have been made to enrollment assistance, including titles, training and sources of funding. All enrollment counselors are required to take the CMS navigator training course, which includes a detailed review of conflict-of-interest and privacy and security standards. The NMHIX has again put out to bid contracts for enrollment entities, with 17 organizations submitting proposals, 13 of which were accepted. The marketing and communications request for proposals (RFP) brought 18 applicants (12 of these in-state), four of whom were chosen, and four groups were selected from the outreach and education RFP, Ms. Dowd said. The Native American outreach now includes

subcontracts with all 22 tribes, nations and pueblos in New Mexico, Ms. Dowd said, with a goal of outreach, education and enrollment to 9,200 Native Americans.

Roxane Spruce-Bly, interim CEO of Native American Professional Parent Resources, Inc. (NAPPR), described plans to complete at least 90,000 encounters as a partner with the state's Native American communities in developing community-based outreach, education and enrollment programs (see handout). The goal is to enroll at least 2,250 individuals in qualified health plans through the NMHIX. There is an opportunity through the ACA to transform Native American health care, Ms. Spruce-Bly said; the benefit cannot be overstated. NAPPR will be working on the Navajo Nation at at least 18 sites where people can go for assistance and to access enrollment counselors. There is also a very strong partnership with NAPPR in IHS facilities, she said, where messaging can be tailored for Native Americans and veterans; the latter group is a target of widespread outreach efforts. Monica Marthell, interim director of health care education and outreach at NAPPR, said she is often asked questions, and is able to answer them, in her native language. NAPPR is planning further involvement with the NMHIX, acting as the Native American service center, by providing a walk-up storefront offering all functions associated with the center and extended service hours.

Ms. Dowd said she has been very impressed with the talent and expertise available within the state and is pleased to report that from January 1 through August 31, \$14.3 million, or 34 percent, of NMHIX expenditures has gone to New Mexico vendors.

### **New Mexico's Readiness to Confront a Public Health Crisis**

Michael Landen, M.D., state epidemiologist, DOH, provided committee members with a detailed presentation on the state's public health preparedness plans, including response to the Ebola virus (see handout). Obesity, chronic disease and substance abuse continue to cause far more damage to New Mexicans than infectious diseases, Dr. Landen said. Detailing differences between pandemic influenza and Ebola, he concluded that the risk of importation of Ebola into New Mexico is extremely low. The DOH investigates more than 10,000 cases of communicable diseases each year, and it is one of 10 states chosen for federal Emerging Infections Program funding; a centralized health department in a state with a small population allows for very timely investigations and interventions.

The Homeland Security and Emergency Management Department coordinates the state's response to all emergencies, Dr. Landen said, and the DOH's Scientific Laboratory Division is the state's response network lab. The DOH's health alert network and access to the CDC's EpiX system assures rapid communication to hospitals, providers and local emergency managers statewide. A network of medical volunteers, regional health care coalitions and the "HAvBED" — "hospital available beds for emergencies and disasters" — electronic tracking system of hospital bed availability further enhance the state's ability to confront a disease outbreak, natural disaster or terrorism event. The DOH receives approximately \$8.5 million annually in federal preparedness funding; nearly \$3 million in additional federal funding for infectious/communicable

disease surveillance; and \$400,000 in state general funds for surveillance, investigation and disease control.

New Mexico's Ebola preparedness plan is directed by the governor and will be posted on the DOH web site the week of October 27, according to Dr. Landen. It will be revised as the international and national response to the outbreak progresses. He detailed steps for evaluation and early recognition of a suspected case, lab testing, contact tracing and new personal protective equipment guidance. The DOH has an Ebola health care team that consults with hospitals, clinics and emergency services on implementation of the guidelines. Quarantine or isolation can be voluntary or court-ordered, he said, and can occur in a variety of settings. New Mexico does have the statutory tools in place to confront a crisis, but Dr. Landen said that Section 24-1-15 NMSA 1978 should be updated to clarify legal definitions of "quarantine" and "isolation" so they are consistent with public health definitions. LCS staff is working on a bill incorporating these changes. In conclusion, Dr. Landen said, pandemic influenza or other viruses transmitted through the air are the greater infectious disease threats to New Mexicans. The risk of Ebola is extremely low, he said, but the state is well-prepared to respond that remote possibility.

Anita Statman, deputy secretary of homeland security and emergency management, provided members with a fact sheet about local and federal coordinated responses to any event of the Ebola virus in New Mexico, including securing temporary housing for isolation and protecting a citizen's civil rights and liberties.

A committee member thanked Dr. Landen for his thorough presentation and suggested that the DOH put out a press release to let people know that they can go to the web site. Another member commented on the public hysteria around airplanes and Ebola. Dr. Landen emphasized that the Ebola virus is not airborne, and the risk of contact from an armrest on an airplane is extremely low. Good protocols for contact-tracing are already in place, he said, and every hospital in the state should be able to evaluate a suspected case and use the tiered system of referral. He also noted there is a Level 1 trauma center at UNM in Albuquerque. Gabrielle Sanchez-Sandoval, general counsel for the DOH, responded to a member's question about enforcement of isolation if a person does not agree to be confined. The DOH experienced this with a tuberculosis outbreak, Ms. Sanchez-Sandoval said, and requested an emergency hearing after hours to obtain a court order. Law enforcement would be involved, she said. Dr. Landen announced that on Friday, October 24, the Indian Affairs Department will host a conference call with tribal leaders and representatives from the CDC, the DOH and the IHS regarding response to the Ebola virus, and he invited interested committee members to participate.

### **Adjournment**

There being no further business, the fifth meeting of the LHHS for the 2014 interim was adjourned at 5:50 p.m.